

Case Number:	CM14-0049919		
Date Assigned:	07/07/2014	Date of Injury:	03/10/2007
Decision Date:	08/18/2014	UR Denial Date:	03/17/2014
Priority:	Standard	Application Received:	04/17/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Plastic and Reconstructive Surgery and is licensed to practice in Maryland, North Carolina and Virginia. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 61 year old male with a reported date of injury on 3/10/07. He is noted to have signs and symptoms of median and ulnar nerve entrapment of the left wrist. Surgical treatment of the left wrist had been certified. Documentation from 10/7/13 notes a blood pressure of 132/87 and a heart rate of 70. Documentation from 2/10/14 notes a blood pressure of 135/89 and a heart rate of 67. He weight is reported to be 191 pounds and approximately 6 feet tall. Recommendation was made to have left carpal tunnel release/Guyon's canal release and preoperative clearance. Response to denial of EKG (Electrocardiogram) and Chest X-ray is that the patient fluctuates from pre-hypertension to Stage II hypertension and he cannot undergo surgery without EKG (Electrocardiogram) and Chest X-ray. Examination from 3/24/14 notes a blood pressure of 175/90 and a heart rate of 67. Examination from 4/2/14 notes that the patient with blood pressure of 146/91 and heart rate of 65. Utilization review dated 4/23/14 did not certify EKG or CXR but UR dated 4/25/14 did certify both EKG and CXR. Utilization review dated 3/17/14 certified left carpal tunnel release, Guyon's canal release and lab work of BMP and CBC. It did not certify an EKG (Electrocardiogram) and Chest X-ray. Reasoning given was based on ODG guidelines. The decision to order pre-operative tests should be guided by the patient's clinical history, comorbidities and physical examination findings. In this case, given the planned procedure, labs including BMP (Basic Metabolic Panel) and CBC (Complete Blood Count) are indicated. The need for a chest X-ray and EKG for the planned procedure is not evident as there are no identified risk factors.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Preoperative Laboratory Tests: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment in Worker's Compensation(updated 05/10/2013) Preoperative Laboratory Testing.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Pain, Preoperative lab testing.

Decision rationale: Based on the utilization review dated 3/17/14 preoperative laboratory studies were not certified but modified to certify BMP (Basic Metabolic Panel) and CBC (Complete Blood Count). Based on review of the medical documentation, there is insufficient justification for routine preoperative laboratory testing. No specific medical condition was noted in the documentation on 2/10/14 or other documentation to warrant general laboratory testing. From ODG, Preoperative additional tests are excessively ordered, even for young patients with low surgical risk, with little or no interference in perioperative management. Laboratory tests, besides generating high and unnecessary costs, are not good standardized screening instruments for diseases. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Preoperative routine tests are appropriate if patients with abnormal tests will have a preoperative modified approach (i.e., new tests ordered, referral to a specialist or surgery postponement). Testing should generally be done to confirm a clinical impression, and tests should affect the course of treatment. (Feely, 2013) (Sousa, 2013) Criteria for Preoperative lab testing:- Preoperative urinalysis is recommended for patients undergoing invasive urologic procedures and those undergoing implantation of foreign material.- Electrolyte and creatinine testing should be performed in patients with underlying chronic disease and those taking medications that predispose them to electrolyte abnormalities or renal failure.- Random glucose testing should be performed in patients at high risk of undiagnosed diabetes mellitus.- In patients with diagnosed diabetes, A1C testing is recommended only if the result would change perioperative management.- A complete blood count is indicated for patients with diseases that increase the risk of anemia or patients in whom significant perioperative blood loss is anticipated.- Coagulation studies are reserved for patients with a history of bleeding or medical conditions that predispose them to bleeding, and for those taking anticoagulants. Thus, as recommended by ODG, the decision to order preoperative laboratory testing should be guided by the patient's clinical history, comorbidities and physical examination findings. There has not been sufficient medical documentation to warrant general laboratory testing. The patient is not sufficiently documented to have a chronic disease, taking medications that would pre-dispose the patient to electrolyte abnormalities, or that there would be an expectation of significant blood loss from the procedure. Thus, without specific detail as to the reasoning for ordering preoperative testing, the request of Preoperative Laboratory Tests is not considered to be medically necessary and appropriate.

Chest X-ray: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment in Worker's Compensation(updated 05/10/2013) Preoperative Testing.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Pain, Preoperative testing, General.

Decision rationale: The patient is a 61 year old male with plans for left carpal tunnel/Guyon's canal release. He has some history of possible hypertension, but otherwise his medical history does not suggest cardiac or pulmonary risk factors. His medication history only includes reference to previous pain medications. From ODG, preoperative testing, general: Preoperative testing (e.g., chest radiography, electrocardiography, laboratory testing, urinalysis) is often performed before surgical procedures. These investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Electrocardiography is recommended for patients undergoing high-risk surgery and those undergoing intermediate-risk surgeries who have additional risk factors. Patients undergoing low-risk surgery do not require electrocardiography. Chest radiography is reasonable for patients at risk of postoperative pulmonary complications if the results would change perioperative management. The medical history does not provide detail that the patient would be at risk of pulmonary complications or that the patient has a medical condition that would require evaluation with a Chest X-ray. The planned surgical procedure should be considered low risk in an ambulatory patient. Therefore, the request of Chest X-ray is not medically necessary and appropriate.

EKG (Electrocardiogram): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment in Worker's Compensation(updated 05/10/2013) Preoperative Testing.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Preoperative electrocardiogram (ECG) Other Medical Treatment Guideline or Medical Evidence: ACC/AHA 2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery.

Decision rationale: The patient is a 61 year old male with plans for left carpal tunnel/Guyon's canal release. He has some history of possible hypertension, but otherwise his medical history does not suggest cardiac or pulmonary risk factors. His medication history only includes reference to previous pain medications. From ODG, Preoperative electrocardiogram (ECG):Recommended for patients undergoing high-risk surgery and those undergoing intermediate-risk surgery who have additional risk factors. Patients undergoing low-risk surgery do not require electrocardiography. Patients with signs or symptoms of active cardiovascular

disease should be evaluated with appropriate testing, regardless of their preoperative status. Preoperative ECGs in patients without known risk factors for coronary disease, regardless of age, may not be necessary. Preoperative and postoperative resting 12-lead ECGs are not indicated in asymptomatic persons undergoing low-risk surgical procedures. Low risk procedures (with reported cardiac risk generally less than 1%) include endoscopic procedures; superficial procedures; cataract surgery; breast surgery; & ambulatory surgery. An ECG within 30 days of surgery is adequate for those with stable disease in whom a preoperative ECG is indicated. (Fleisher, 2008) (Feely, 2013) (Sousa, 2013)Based on the medical records reviewed, there is not sufficient evidence to warrant ECG. The patient is undergoing a low-risk procedure and only has evidence of possible hypertension. Further from ACC/AHA 2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery: Preoperative and postoperative resting 12-lead ECGs are not indicated in asymptomatic persons undergoing low-risk surgical procedures. Also, with respect to hypertension, 'Numerous studies have shown that stage 1 or stage 2 hypertension (systolic blood pressure below 180 mm Hg and diastolic blood pressure below 110 mm Hg) is not an independent risk factor for perioperative cardiovascular complications.' Thus, based on the medical records provided, EKG (Electrocardiogram) is not medically necessary and appropriate.